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ABSTRACT

Cognitive behavioral psychology is a new theoretical orientation. When applied in treatment, it is known as cognitive behavior therapy (CBT). CBT, although based primarily on an information processing model, rests firmly on the twin pillars of both behaviorism and cognitive psychology. Today cognitive therapy and behavioral therapy are terms which can almost always be used interchangeably. Theoretically CBT seeks primarily to change cognitions to alter behaviors, and to modify cognitions to affect emotions. A person's faulty cognitions, illogical or dysfunctional thoughts, and irrational beliefs will lead to self-defeating behaviors and unhappiness. To the extent that the cognitive behavioral therapist believes that his or her clients have blindspots, hold blurred perceptions, entertain some self-deceptions, and continually engage in certain behaviors that cause anxiety but which they cannot change on their own, the techniques he or she uses must be effective in dealing with these sorts of problems. In general, CBT is considered to be an information processing psychology because it suggests to a great extent getting people to think differently about themselves and their lives after examining data in newly structured ways; the expectation is that they will then act differently. Time, degree of client psychopathology, and the level of the patient's intelligence are not as problematic for CBT as they are in psychoanalysis. For these reasons CBT is often quite suitable for child psychology related cases. (ABL)

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Cognitive Behavior Therapy: Notes on Theory and Application With Children

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Abstract

Cognitive behavioral psychology is a new theoretical orientation; and, when applied in treatment, it is known as cognitive behavior therapy (CBT). CBT, although based primarily on an information processing model (Lehman & Salovey, 1990), rests firmly on the twin pillars of both behaviorism and cognitive psychology (Mahoney, 1974; Meichenbaum, 1974, 1977). Practitioners in all settings should at least be aware of CBT.

Cognitive Behavior Therapy:
Notes on Theory and Application with Children

"Scientific psychology," for approximately 50 or so years and until recently, was dominated by a philosophy of science known as behaviorism (Baars, 1986). It seems to me that behaviorism was a way for psychology to gain greater acceptance from physical scientists and others outside psychology; for, when dealing only with observables (observed discrete behaviors), a strong claim for scientific precision can be made legitimately. This was all, of course, based on the notion that psychology <u>is</u> the study of behavior. However, this observable only psychology (of behavior) is rather radical, and also limiting, inasmuch as many behaviorists denied the legitimacy or at least the importance of non-observable ideas; e.g., thinking, consciousness, feelings, motives, purposes, images, knowledge, plans, or even the self. Nevertheless, behavior therapy--based upon the "conditioning" work of Watson, Skinner, and Pavlov--per se, without regard to cognition, was until recently quite popular with non-psychodynamically oriented practitioners. Perhaps behavior therapy's popularity was due to often quick results with claims of virtually no symptom substitution.

More recently, and for the most part initially only with research psychologists, there has been a transition away from unilateral behaviorism and toward a new dominant metatheoretical position that emphasizes cognitively mediated processes; i.e., thoughts, affect, behavior, and emotions. Baars (1986) wrote that the decade roughly from 1955 to 1965 saw a quiet revolution in thought take place among the research psychologists with a new (cognitive) point of view; he further stated that cognitive psychology has for all intents and purposes replaced behavioral psychology in a sort of scientific, paradigmatic shift, the sort elucidated by Kuhn (1962).

> Kuhn propounded the notion that scientific knowledge is not merely a cumulative linear progression; instead, after a period of consolidation and quiescence, scientific change takes place when old theories and methods are broken down and replaced. Hence, advances in thought occur via spasmodic paradigmatic change, which are then followed by another period of stability, only to be completely replaced at some later date. (Sigmon, 1990, p. xii)

Perhaps Neisser's (1967) classic work not only named but also whispered about what was to later become a significant theoretical revolution in psychology. Although this change first began with human experimental psychology, it now also encompasses greatly the realm of applied professional psychology as well. In fact, since 1973, interest in cognitive approaches among therapists has increased 600% (Norcross, Prochaska, & Gallagher, 1989).

Exactly how, then, are the cognitive and behavioral approaches brought together in therapy? It is where symbolic cognitive processes are emphasized in order to acquire, eliminate, or even to maintain certain behaviors. Today, it is safe to say that cognitive therapy and behavioral therapy are terms that can almost always be used interchangeably:

> These approaches all share a theoretical perspective that assumes that internal covert processes called thinking or cognition occur, and that cognitive events may mediate behavior change. Furthermore, these approaches all assume that behavioral change does not have to involve elaborate cognitive mechanisms. In some forms of therapy the interventions may have very little to do with cognitive appraisals and evaluations, but may be heavily dependent upon client action and behavior change. (Dobson & Block, 1988, p. 6)

Theoretically, therefore, CBT seeks primarily to change cognitions to alter behaviors, and, to modify cognitions to affect emotions. Dobson (1988) discussed this as follows:

> "cognitive-behavioral" therapies are those that assume that patterns of cognition shape the emotional and behavioral consequences of that cognition. Therapy approaches that do not assume cognitive mediation, or see the concept of cognition as unnecessary--primarily those based on classical and operant conditioning--are not considered here as "cognitive-behavioral." Similarly, therapies that focus exclusively on intrapsychic processes or insight, but that do not explicitly reference psychotherapy outcome by behavioral change are not "cognitive -behavioral." Generally, then, cognitive-behavioral therapies focus on relatively discrete behavioral problems, and these

> therapies attempt to induce psychotherapeutic gain through changes in the cognitive-behavior complex. (pp. ix-x)

A person's faulty cognitions, illogical or dysfunctional thoughts, and irrational beliefs will lead to self-defeating behaviors and unhappiness. And, in turn, could eventually result in depression, anxiety, phobias, and schizophrenic-like behavior. In essence, I believe that the pathological process of the common psychological disorders centers around certain aberrations in thinking.

To the extent that the cognitive behavioral therapist believes that one's clients have blindspots, hold blurred perceptions, entertain some self-deceptions, and continually engage in certain behaviors that cause anxiety but cannot change on their own, the techniques utilized must, naturally, be able to deal effectively with these sorts of problems. The strategies and procedures used in CBT can be classified into two broad areas, behavioral and cognitive. Moreover, CBT is often done with one or more of four important techniques: changing reinforce-ment schedules, relaxation training or desensitization, skill training or rehearsal, and cognitive-restructuring (replacing irrational thoughts and beliefs with rational ones). The active training/rearranging of stimulus-response contingencies engaged in by the CBT therapist is the more behavioral aspect, while the more direct cognitive work seeks to help the client change more immediately one's own thinking. Skill training involves teaching the patient certain proficiencies which may be lacking from his/her behavioral repertoire, and then having the patient practice them outside of the therapy session as "homework"; and, having acquired a new cognitive coping skill, this could reduce the patient's anxiety by having gained confidence in one's own self-efficacy. Cognitive restructuring involves getting the patient to see oneself differently, and this can be accomplished, by, for example, therapist questioning, rational disputation, and guided conversation. Having portrayed CBT in this way, it is seen that this is a somewhat integrative system of psychotherapeutic practice.

Perhaps three of the most widely known cognitive behavior therapists are the psychiatrist Aaron T. Beck as well as the psychologists Albert Ellis and Donald Meichenbaum. Beck is well known for his pioneering work

in the cognitive treatment of depression and emotional disorders. Beck (1976) wrote that "cognitive techniques are most appropriate for people who have the capacity for introspection and for reflecting about their own thoughts and fantasies" (p. 216). As such, Beck targets "direct, tangible [cognitive] distortions of reality," "automatic thoughts" and "illogical thinking." Ellis and Meichenbaum, also CBT pioneers, are known for their systems. Ellis (1962) popularized "rational emotive therapy" (RET), and Meichenbaum (1974, 1977) "cognitive behavior modification" (CBM). Ellis's system can be characterized as vigorously disputing or confronting rigid "irrational beliefs" with therapist questioning and "assigning homework" to change cognitions to minimize current self-defeating behavior and future disturbability by becoming more realistic (i.e., desiring rather than demanding) in general outlook (Wolman, 1989). Meichenbaum, meanwhile, who focuses on "internal dialogues," is noted for "skills training" with the "utilization of available information" along with "rehearsal."

In general, CBT is considered an information processing psychology because it suggests, to a great extent, getting people to think differently about themselves and their lives after examining "data" in newly structured ways; and then, they will act differently. (CBT differs from purely cognitive therapies because it may use behavioral means to alter a client's views [Lehman & Salovey, 1990].) However, where CBT differs from most psychodynamic psychotherapies in this regard is that with CBT the therapist takes a very direct, active role. In sharpest contrast to the ordinarily highly directive CBT would be psychoanalytic psychotherapy--exemplified by the psychoanalyst's passive role where occasional interpretations are given.

Another major difference between CBT and psychoanalysis is the latter's emphasis on resolving intrapsychic conflicts (e.g., id vs. superego) and helping the analysand to get in touch with repressed affect. Moreover, in psychoanalysis, therapy involves restarting stalled (psychosexual stage) development. This is done through analysis of real and transference reactions, in addition to interpretations of associations, dreams, and fantasies.

In child analysis, as with adults, the more intact the ego, the greater the chances are for success. Hence, prognosis is better for the

less pathological neurotic than the psychotic patient; the latter has difficulty distinguishing primary process (fantasy) from secondary process (reality) thinking. Child psychoanalysis, due to the course of natural development, could be viewed as being more complex than analysis with adults.

> The ego of the young child has the developmental task to master on the one hand orientation in the external world and on the other the chaotic emotional states which exist within himself. It gains its victories and advances whenever such impressions are grasped, put into thoughts or words, and submitted to the secondary process. (A. Freud, 1965, p. 32)

Nevertheless, child analysis is actually quite well suited for certain youngsters, for it utilizes as a rich source of material night-fears, daydreams, and observations of play. Moreover, mind-created turmoil and infantile complexes would be more open to view than with adults; these things would be less distorted because cover-memories or amnesia are not as strong with the young (A. Freud, 1965).

Not only is psychoanalysis better suited to patients with a more intact ego, but with higher intelligence and more wisdom as well. This is because psychoanalysis relies more on self-discovery. Although enlightenment and self-understanding with less direct intervention/assistance from a therapist may ultimately be more profound for the patient, it is usually a rather slow process; and, being that there is less active involvement on the part of the analyst, the patient may not take action to change one's circumstances until such self-realization occurs--and even then the action taken by the client on one's own, outside the analyst's office, may be insufficient.

As pointed out above, time (which impacts on fiscal resources), degree of client psychopathology, and the level of the patient's intelligence are not as problematic for CBT as they are in psychoanalysis. For these reasons, CBT is often quite suitable for child psychology related cases.

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